No. 85-1763

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

—against—

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as Administrator/ Commissioner of the New York City Human Resources Administration,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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April 24, 1986

Question Presented

Whether institutional health care providers participating in the Medicaid program must bear the risk of non-payment by Medicaid patients of that portion of the cost of their care for which the patients are legally responsible.

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IN THE

Supreme Court of the United States

October Term, 1985

No. 85-

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

—against—

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as Administrator/ Commissioner of the New York City Human Resources Administration,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Petitioner Florence Nightingale Nursing Home ("Florence Nightingale") respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit, entered January 24, 1986, which (a) reversed a judgment of the United States District Court for the Southern District of New York, (b) vacated an injunction entered by that District Court and (c) held that Florence Nightingale was not entitled to be reimbursed by respondents for the debts owed to it by certain Medicaid patients for skilled nursing services which Florence Nightingale was unable to collect from the patients.

Opinions Below

The opinion of the Court of Appeals is reported at 782 F.2d 26 (2d Cir. 1986). A copy is annexed as Exhibit A. The opinion of the District Court which granted Florence Nightingale's motion for partial summary judgment is not reported. A copy is annexed as Appendix B. An earlier opinion of the District Court, upon which its decision granting summary judgment was based, is reported at 570 F. Supp. 285 (S.D.N.Y. 1983). A copy is annexed as Appendix C.

Jurisdiction

The judgment of the Court of Appeals was dated and entered January 24, 1986. A copy is annexed as Appendix D. This petition is filed pursuant to 28 U.S.C. § 1254(1), within the time allowed by law.

Statutes

The statutory provision involved in this action is 42 U.S.C. § 1396a(a)(13)(A). A copy is annexed as Appendix E. A relevant portion of the legislative history of that statute, S. Rep. No. 1230, 92d Cong., 2d Sess. 287-288 (1972), is annexed as Appendix F.

Statement of the Case

A. The Structure of Medicaid

In 1965, Congress established Medicaid under Title XIX of the Social Security Act to provide medical assistance to the needy. *See* 42 U.S.C. § 1396 *et seq.* Under the Medicaid program, the federal government provides money to participating states to reimburse hospitals, nursing homes and other health care providers for costs they incur in providing services to eligible Medicaid recipients. In turn,

the Medicaid statutes provide that each participating state must create a plan describing its administrative procedures and file that plan with the United States Department of Health and Human Services ("HHS"). The plan established by each state must comply with federal law.

B. The Parties

Respondent Cesar Perales is the Commissioner of the New York State Department of Social Services (the "State"), the state agency responsible for administering the Medicaid program in New York State. At all relevant times, New York State has participated in the Medicaid program.

Respondent George Gross is the Administrator/Commissioner of the New York City Human Resources Administration (the "City"). The City acted as the agent of the State in administering the Medicaid program in New York City from January 1, 1976, until December 1, 1978.

Florence Nightingale is a licensed nursing home located in New York, New York. Pursuant to an agreement with the State, Florence Nightingale provides skilled nursing services to Medicaid patients.[1] Florence Nightingale receives reimbursement for those services pursuant to the Medicaid statutes, 42 U.S.C. § 1396 *et seq.* Florence Nightingale provides its services to approximately 1,400 Medicaid recipients each year.

C. Reimbursement for Uncollectible Debts of Medicaid Patients

Florence Nightingale's claims in this action involve an issue common to many, if not all, institutional health care

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[1] None of the parties to this action is a corporation. None has, therefore, corporate parents, subsidiaries or affiliates.

providers in the United States which participate in the Medicaid program. Under federal law, a state participating in the Medicaid program may require a Medicaid patient whose income is above a certain level to pay the provider for a portion of the cost of his or her care. In New York, the Medicaid patient's contribution to the cost of care is termed "Net Available Monthly Income," or N.A.M.I. N.A.M.I. represents the gross income of the Medicaid patient, including pension and social security benefits, minus the patient's "personal needs allowance." *See* 42 C.F.R. §§ 435.725, 435.832. Other states also require Medicaid patients to contribute a portion of their income to the overall cost of their care.

The parties agreed below that, if a Medicaid patient pays the required amount to the provider, or if the provider fails to make a reasonable effort to collect it from the patient, the provider is not entitled to reimbursement from the State for any uncollected amount. The issue presented in this action arises when the Medicaid patient fails or refuses to satisfy his or her obligation to pay the required amount to the provider, and the provider cannot, despite the exercise of reasonable efforts, collect the amount due from the patient.

Over the years, the State has taken inconsistent positions with respect to its obligation to reimburse providers, such as Florence Nightingale, for uncollectible N.A.M.I. Prior to July 2, 1979, the State recognized its obligation to reimburse providers for a Medicaid recipient's N.A.M.I. which the provider could not collect. On July 2, 1979, the State announced retroactively that, effective June 1978, it would not reimburse Florence Nightingale or other Medicaid providers for uncollectible N.A.M.I.

D. Proceedings in the District Court

Florence Nightingale commenced this action on October 16, 1980, pursuant to 28 U.S.C. § 1331, challenging the validity of the change in the State's reimbursement policy. Florence Nightingale sought, among other things, declaratory and injunctive relief which, if granted, would require the State and the City to continue to reimburse Florence Nightingale and other Medicaid providers for uncollectible N.A.M.I.

The State moved to dismiss Florence Nightingale's claims by notice of motion returnable December 12, 1980. By opinion dated July 27, 1983 (reported at 570 F. Supp. 285), and order entered October 11, 1983, the District Court denied the State's motion to dismiss and held, among other things, that Florence Nightingale had stated a valid claim under the Medicaid statutes for reimbursement of the uncollectible amounts due from Medicaid patients.

E. The Ruling of the District Court

By notice of motion dated November 16, 1984, Florence Nightingale moved for summary judgment on its claim for reimbursement for uncollectible N.A.M.I. By endorsed memorandum dated July 12, 1985, the District Court granted the motion insofar as it sought declaratory and injunctive relief. In reliance upon its prior opinion reported at 570 F. Supp. 285, the District Court held that the Medicaid statutes require the State and City to reimburse Florence Nightingale for the reasonable costs of providing patient services, including that portion of the costs represented by uncollectible patients' N.A.M.I. The District Court entered judgment on September 13, 1985, and the State and City thereafter filed timely notices of appeal.

F. The Ruling of the Court of Appeals

In its opinion, based largely upon an *amicus* brief filed by HHS, the Court of Appeals reversed the judgment of the District Court, reasoning as follows:

> During the relevant time period, section 1396a (a)(13)(E) required a state plan to provide for 'payment of the skilled nursing facility and intermediate care facility *services provided under the plan* on a reasonable cost basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of the cost findings methods approved and verified by the Secretary . . .' (emphasis added). The District Court determined that the statute 'clearly calls for a cost-based reimbursement program.' 570 F. Supp. at 288. But the District Court did not reckon with the fact that 'reasonable cost basis' applies only to the cost of 'services provided under the plan.' In authorizing reimbursement of providers for Medicaid care costs, Congress clearly intended *not* to reimburse for costs not covered by Medicaid. NAMI represents the amount that a patient is required to contribute toward his or her care. This contribution reduces the amount that the patient is eligible to have paid on his or her behalf under the Medicaid program. *See Friedman* v. *Berger,* 547 F.2d 724, 726-27 (2d Cir. 1976), *cert. denied,* 430 U.S. 984, 97 S.Ct. 1681, 52 L.Ed.2d 378 (1977). It is arguable that NAMI payments remaining uncollected despite reasonable collection efforts are an overhead cost reimbursable like all other costs of providing covered services. But the Secretary's view, expressed in an amicus brief, that uncollected NAMI is not reimbursable is the more reasonable interpretation and is entitled to 'particular deference.' *DeJesus* v. *Perales,* 770 F.2d 316, 327 (2d Cir. 1985).

782 F.2d at 28-29 [A-4-5] (emphasis in original; footnote omitted).

Reasons for Granting the Writ

This case presents an important question of federal law which affects not only Florence Nightingale, but also all other institutional health care providers throughout the United States which are unable to collect the debts owed them by Medicaid patients for that portion of the overall cost of their care for which the patients are responsible under the Medicaid statutes.

The Court of Appeals' decision not only tortures the language of the governing statute, but is flatly inconsistent with the intent of Congress to compensate Medicaid providers for the costs incurred in providing services to Medicaid patients. By ruling that health care providers are not entitled to reimbursement for the uncollectible debts of Medicaid patients, the Court of Appeals has, in effect, made the provider the guarantor, and ultimate payor, of a portion of the overall cost of a patient's care. If permitted to stand, the Second Circuit decision will (a) undermine the financial ability of providers to provide an appropriate level of care to Medicaid patients and (b) cause providers to decline admission to those Medicaid patients whom they perceive to represent an undue credit risk. In enacting the Medicaid statutes, Congress did not intend that providers themselves bear a portion of the cost of a patient's care, nor did it intend that creditworthiness be a factor in the provider's determination to admit or reject a patient otherwise eligible for Medicaid assistance.

The decision of the Court of Appeals also requires review, because it conflicts, at least in principle, with the decision of the Court of Appeals for the Tenth Circuit in *Seneca Nursing Home* v. *Secretary of Social and Rehabilita-*

tion Services, 604 F.2d 1309 (10th Cir. 1979). There, the Court of Appeals, in partial reliance upon the federal Medicaid laws, ruled that nursing homes were entitled to reimbursement from the state agency for uncollectible patient contributions.

Given the importance of this issue to institutional health care providers and patients, the degree to which the decision of the Court of Appeals conflicts with the language and intent of the Medicaid statutes and the apparent conflict with a prior decision of another Court of Appeals, this Court should grant this petition for a writ of certiorari.

I.

This Case Raises a Significant and Recurring Issue Concerning the Right of Institutional Health Care Providers to Reimbursement Under the Medicaid Statutes.

The resolution of the issue presented in this case will affect every hospital, nursing home and intermediate care facility that participates in the Medicaid program and is unable to collect the full amount of the statutorily-mandated indebtedness owed to them by each of their Medicaid patients. According to HHS, there are more than 21,000 of these institutions in the United States,[2] which provide services to more than 5,000,000 Medicaid patients.[3]

Although it cannot be calculated with mathematical certainty, the amount of money at stake in this controversy is

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[2] This information is set forth in a computer printout created by HHS, dated March 31, 1986, entitled "Provider Count Table."

[3] *See* United States Department of Health and Human Services, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement, 1984-85*, ISSN 0037-7910, Table 153, p. 220.

substantial. In the District Court, Florence Nightingale sought recovery of an average of more than $24,000 per year of uncollectible patient debt. If the uncollectible debt of each of the more than 21,000 Medicaid providers throughout the United States was just five percent of the indebtedness that Florence Nightingale was unable to collect, *i.e.*, $1,200 per year, the total amount of such indebtedness would be more than $25,200,000 per year.[4] The issue presented in this case is important, merits more than the superficial analysis and summary disposition afforded by the Court of Appeals and requires a definitive adjudication by this Court.

II.

The Decision of the Court of Appeals Was Patently Erroneous.

In 1972, Congress amended the Medicaid statutes to require participating states to reimburse health care providers for services they provide to Medicaid patients on a "cost related basis." 86 Stat. 1426, 42 U.S.C. § 1396a(a)(13)(E). Congress intended that this section would eliminate "flat rate" reimbursement systems that had been used by some states, which tended to compensate providers unfairly for the cost of the services they provided to Medicaid patients. S. Rep. No. 1230, 92d Cong., 2d Sess. 287-288 (1972). *See generally Florida Department of Health and*

[4] The State advised the District Court by letter dated August 14, 1985, that for the fiscal year 1983-1984 health care facilities in New York State reported N.A.M.I. of $300,000,000. Florence Nightingale estimates that approximately three percent of its N.A.M.I. is uncollectible. Thus, if other Medicaid providers in New York State experience the same percentage of uncollectible N.A.M.I. as does Florence Nightingale, approximately $9,000,000 would be involved with respect to providers located in New York State alone.

Rehabilitative Services v. *Florida Nursing Home Ass'n*, 450 U.S. 147 (1981).

In 1980, § 1396a(a)(13)(E) was replaced by the present § 1396a(a)(13)(A), which provides in relevant part:

> A State plan for medical assistance must—
>
> * * *
>
> (13) provide—
>
> (A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates . . . which the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . . .

The State and City conceded below that this 1980 amendment did not alter the substance of the former provision for purposes of this case.

Florence Nightingale contends that, under 42 U.S.C. § 1396a(a)(13)(A), it is entitled to be fully reimbursed, on a reasonable and adequate cost basis, for the costs it incurs in providing services to Medicaid patients. Under the Medicaid statutes, it cannot be compelled by the State to be either a payor, or a guarantor of payment, of any portion of the cost of those services. Unless Florence Nightingale is reimbursed for that portion of the cost of care that it is unable, after reasonable efforts, to collect from its patients, it will be deprived of full reimbursement of its costs in contravention of those statutes. The District Court agreed and entered judgment accordingly. The Court of Appeals, basing its decision on three grounds,

rejected the District Court's interpretation of the governing statute.

First, the Court of Appeals said, uncollectible debts of Medicaid patients do not result from "services provided under the plan." [A-4] That ruling contorts the plain language of the statute. The phrase "services provided under the plan" was intended to prevent reimbursement for "luxury" or similar services, which are not at issue here. S. Rep. No. 1230, 92d Cong., 2d Sess. 287-288 (1972). There is no indication that that phrase was intended to diminish reimbursement to the provider of its overall out-of-pocket costs simply because the Medicaid patient was obliged by law to pay a portion of those costs. The Court of Appeals' reading of the statute simply begs the question.

Second, the Court of Appeals ruled, in effect, that uncollectible debts of Medicaid patients are not "costs." [A-4] That ruling too is plainly erroneous. When Florence Nightingale provides nursing services to a patient, it incurs costs, whether for labor, materials or both. It then bills the State for a portion of those costs and seeks to recover the balance from the patient in the form of the patient's N.A.M.I. If Florence Nightingale cannot collect from the patient that portion of the total cost of care that the patient is obligated to pay, that portion may become a "bad debt," but it still represents a cost. The Court of Appeals' contrary conclusion is patently erroneous.

Third, the Court of Appeals ruled, the view expressed by HHS in an *amicus* brief, namely, "that uncollected NAMI is not reimbursable is the more reasonable interpretation," was entitled to " 'particular deference.' " [A-4-5] The Second Circuit has recognized that, "[a]s program after program has evolved, there has developed a degree of complexity in the Social Security Act and particularly the

regulations which make them almost unintelligible to the uninitiated." *Friedman* v. *Berger*, 547 F.2d 724, 727 n.7 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977). Given that complexity, the Court of Appeals looked to HHS to proffer a proper reading of the Medicaid statutes. Its deference to the view of HHS in this case, however, though understandable, was entirely unwarranted.

The regulations adopted by HHS with regard to uncollectible patient debts are fundamentally inconsistent with the basic purpose of the Medicaid statutes. In *James* v. *Harris*, 499 F. Supp. 594 (M.D. Ala. 1980), *aff'd on opinion below*, 650 F.2d 814 (5th Cir. 1981), the district court said:

> It is clear that the purpose of the Social Security Act and the regulations formulated thereunder is for the cost of nursing care to be shared by the patient, the state, and the federal government.

499 F. Supp. at 597. It is not the purpose of the Medicaid statutes—indeed, it is contrary to the purpose of those statutes—to require providers to share in the cost of patient care. The interpretation of those statutes by HHS, which would require providers to absorb the uncollectible debts of Medicaid patients, is therefore utterly inconsistent with the language and basic purpose of the Medicaid statutes.

The interpretation of HHS is also inconsistent with the relationship Congress intended to achieve with respect to the reimbursement of providers under the Medicare and Medicaid programs. Under the Medicare statutes, a provider of health care services is entitled to reimbursement for the "reasonable cost of such services." 42 U.S.C. § 1395f(b). Pursuant to those statutes, HHS promulgated 42 C.F.R. § 405.420, which states:

> (a) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:
>
> (1) The debt must be related to covered services and derived from deductible and co-insurance amounts.
>
> (2) The provider must be able to establish that reasonable collection efforts were made.
>
> (3) The debt was actually uncollectable when claimed as worthless.
>
> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

Under the Medicare program, therefore, HHS recognizes that providers, under appropriate circumstances, are to be reimbursed for uncollectible debts of patients.

In 1972, Congress authorized the states, at their option, to reimburse Medicaid providers in the same manner as Medicare providers. The Senate Report which preceded enactment of the 1972 amendments to the Medicaid statutes stated:

> [T]he committee does not intend that this provision [the predecessor of 42 U.S.C. § 1396a(a)(13)(A)] should require use of the specific medicare reasonable cost reimbursement formula by States for purposes of reimbursing skilled nursing homes and intermediate care facilities under medicaid, *although States are free to choose this option.*"

S. Rep. No. 1230, 92d Cong., 2d Sess. 287 (1972) [F-1-2] (emphasis added). Inasmuch as (a) a provider would be entitled under Medicare to be reimbursed for the kind of uncollectible patient debts involved in this case and (b) Congress authorized states to reimburse providers for their costs under Medicaid in the same manner as under Medi-

care, the position of HHS that the Medicaid statutes prohibit reimbursement for the uncollectible debts of Medicaid patients is plainly wrong.[5]

Because HHS has adopted regulations that are flatly inconsistent with the purpose and intent of the Medicaid statutes, its interpretation of the governing statute is entitled to no deference whatsoever. As this Court stated in *Southeastern Community College* v. *Davis*, 442 U.S. 397 (1979):

> Although an agency's interpretation of the statute under which it operates is entitled to some deference, this deference is constrained by our obligation to honor the clear meaning of a statute, as revealed by its language, purpose, and history.

442 U.S. at 411 (citation omitted). In this case, the Court of Appeals erred in adopting an interpretation of the Medicaid statutes that is contrary to both the language and the purpose of those statutes. Review by this Court is necessary, therefore, to compel compliance by federal and state authorities with the plain meaning and intent of the statutes involved.

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[5] The apparent reason for this inconsistency is that HHS developed its views not contemporaneously with the enactment of the statute, but in response to the events which gave rise to this litigation. Although the relevant portion of the statute was enacted in 1972, it was not until August 29, 1982, when the HHS Grant Appeals Board decided *New York State Department of Social Services*, Docket No. 81-161 NY-HC, Decision No. 284, that HHS officially articulated its position that providers were not entitled to reimbursement for the uncollectible N.A.M.I. owed them by their Medicaid patients. The Grant Appeals Board based its decision not on the language or legislative history of the Medicaid statutes, but on the language of the Medicaid regulations. Thus, in the present case, the views expressed by HHS in its *amicus* brief in the Court of Appeals were nothing more than self-serving conclusions, following an adverse decision in the District Court, based solely upon the language of regulations it had prepared and adopted.

III.

The Decision of the Court of Appeals Conflicts in Principle With a Decision of the Tenth Circuit.

In *Seneca Nursing Home* v. *Secretary of Social and Rehabilitation Services,* 604 F.2d 1309 (10th Cir. 1979), the Court of Appeals for the Tenth Circuit ruled that nursing homes were entitled to reimbursement from the State of Kansas for uncollectible debts owed them by Medicaid patients. Although the Tenth Circuit rendered its decision on the basis of a Kansas statute, it stated:

> In so holding we are influenced by the fact the Federal Social Security Act sections involved, 42 U.S.C. §§ 1381 *et seq.* (Title XVI) and 42 U.S.C. §§ 1396 *et seq.* (Title XIX), provide federal grants to carry at least a major portion of the medical and other care for these individuals.

604 F.2d at 1315. It is apparent that the Tenth Circuit holds a view with respect to the obligation of a state to reimburse providers for uncollectible patient debts that is contrary to the decision of the Second Circuit. This Court should therefore review the judgment rendered below to resolve that conflict.

Conclusion

The issue presented here has nationwide significance. Reimbursement of providers under the Medicaid program for the full cost of patient care should turn not upon geography, but upon the language and intent of the governing federal statutes. Only by a review of the judgment below can this Court assure a uniform national result. For the foregoing reasons, this Court should issue a writ of certiorari to the United States Court of Appeals for the Second Circuit.

April 24, 1986

Respectfully submitted,

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APPENDIX A

Florence Nightingale Nursing Home v. *Cesar Perales, individually and as Commissioner of the New York State Department of Social Services, and George Gross, individually and as Administrator/Commissioner of the New York City Human Resources Administration*

782 F.2d 26 (2d Cir. 1986)

UNITED STATES COURT OF APPEALS

SECOND CIRCUIT

Nos. 585, 586—August Term 1985

Argued: December 12, 1985—Decided: January 24, 1986

Docket Nos. 85-7755, 85-7759

FLORENCE NIGHTINGALE NURSING HOME,

Plaintiff-Appellee,

v.

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and George Gross, individually and as Administrator/Commissioner of the New York City Human Resources Administration,

Defendants-Appellants.

Before:

KAUFMAN, TIMBERS and NEWMAN,

Circuit Judges.

JON O. NEWMAN,

Circuit Judge:

The issue on this appeal is whether losses resulting from non-payment of money owed by Medicaid patients, despite reasonable collection efforts, are to be borne by the medical care providers to whom the money is owed or are to be reimbursed out of public funds. The State of New York and the City of New York appeal from a judgment of the District Court for the Southern District of New York (Richard Owen, Judge) granting appellee Florence Nightingale Nursing Home ("Nightingale") partial summary judgment and enjoining the State and City from refusing to

reimburse Nightingale for amounts owing from Medicaid patients. Appellants contend that the District Court's decision was incorrect because the reimbursement Nightingale seeks is prohibited by federal statutes and regulations. The State also argues that it should have been allowed to implead the Department of Health and Human Services ("HHS"). Because we agree with appellants' view of federal law, we reverse the reimbursement order and need not reach the third-party issue.

BACKGROUND

New York State is a participant in the Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, which provides federal financial assistance to states that choose to pay certain medical expenses of the needy. Every state that participates must submit a plan describing its medical assistance program. Upon approval of its plan by the Secretary of HHS, the state becomes eligible for partial federal reimbursement of expenditures made in accordance with the approved plan. Individuals eligible for Medicaid do not receive direct payments for their medical expenses. Instead, the institution providing care bills the state, at rates established by the state, for allowable Medicaid care costs incurred and obtains reimbursement. The state in turn bills the Health Care Financing Administration of HHS, which then reimburses the state at the specified federal financial participation rate (50 percent in New York).

Medicaid recipients who are admitted to nursing homes and who have income exceeding a specified level must pay for a portion of their care. The amount to be paid by the patient is determined by subtracting from the patient's income a relatively low "personal needs allowance." Under New York State's medical assistance program, the amount

that remains is referred to as "net available monthly income" or "NAMI." [1] Between July 1, 1976, and July 2, 1979, the State imposed the initial burden of collecting NAMI on institutional providers such as Nightingale but permitted resubmission of bills when providers were unable to collect the funds due. In those cases, the State [2] paid the providers the amounts of uncollected NAMI. The State then changed its policy, advising providers that they and not the State would be responsible for unpaid NAMI. This change was retroactive, effective June 1978.

Nightingale sued, seeking to enjoin the State from refusing to reimburse it for NAMI it claims is owing and uncollectible from Medicaid patients. The District Court denied the State's motion to dismiss the action, *Florence Nightingale Nursing Home* v. *Blum,* 570 F.Supp. 285 (S.D.N.Y. 1983), and later granted Nightingale partial summary judgment on the ground that the federal statutory and regulatory scheme requires states participating in the Medicaid program to bear the risk of patient non-payment. The State and City appealed the ensuing injunction ordering prospective reimbursement. The claim for retrospective reimbursement remains pending.

DISCUSSION

The District Court's reasoning, expressed in its ruling on the motion to dismiss, is that 42 U.S.C. § 1396a(a)(13)(E), 42 C.F.R. § 447.15, and *Seneca Nursing Home* v. *Secretary of Social and Rehabilitation Services of Kansas,*

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[1] The federal regulations refer to this as "[a]pplication of patient income to the cost of care," 42 C.F.R. §§ 435.725, 435.832 (1984).

[2] Prior to December 1, 1978, the New York State Department of Social Services delegated to the New York City Human Resources Administration the task of receiving and evaluating claims by New York City nursing homes for services rendered to New York City residents.

604 F.2d 1309 (10th Cir. 1979), support the conclusion that institutional providers have a right to reimbursement from the State for uncollectible NAMI. We disagree.

During the relevant time period, section 1396a(a)(13)(E) required a state plan to provide for "payment of the skilled nursing facility and intermediate care facility *services provided under the plan* on a reasonable cost basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of the cost finding methods approved and verified by the Secretary . . ." [3] (emphasis added). The District Court determined that the statute "clearly calls for a cost-based reimbursement program." 570 F.Supp. at 288. But the District Court did not reckon with the fact that "reasonable cost basis" applies only to the cost of "services provided under the plan." In authorizing reimbursement of providers for Medicaid care costs, Congress clearly intended *not* to reimburse for costs not covered by Medicaid. NAMI represents the amount that a patient is required to contribute toward his or her care. This contribution reduces the amount that the patient is eligible to have paid on his or her behalf under the Medicaid program. *See Friedman* v. *Berger*, 547 F.2d 724, 726-27 (2d Cir. 1976), *cert. denied*, 430 U.S. 984, 97 S.Ct. 1681, 52 L.Ed.2d 378 (1977). It is arguable that NAMI payments remaining uncollected despite reasonable collection efforts are an overhead cost reimbursable like all other costs of providing covered services. But the

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[3] Section 1396a(a)(13)(E) was amended in 1980 and was replaced by the present section 1396a(a)(13)(A), which requires that state plans provide for payment to providers based on "rates . . . which the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . ." Pub. L. No. 96-499, § 962(a) (1980). *See also* Pub. L. No. 97-35, § 2173(a)(1)(C) (1981) (renumbering subsections).

Secretary's view, expressed in an amicus brief, that uncollected NAMI is not reimbursable is the more reasonable interpretation and is entitled to "particular deference." *DeJesus* v. *Perales*, 770 F.2d 316, 327 (2d Cir. 1985).

This reading of the statute is plainly supported by the federal regulations, which make clear that state Medicaid agencies may not pay institutions any amounts that are the patient's responsibility. The regulations state that "[t]he agency must reduce its payment to an institution, for services provided to an individual . . . , by the amount that remains after deducting the amounts specified in paragraph (c) of this section [*i.e.*, the individual's personal needs allowance], from the individual's income." 42 C.F.R. §§ 435.725, 435.832 (1984). The regulations are consistent with the statutory plan that Medicaid funds not be paid to reimburse those costs that patients with resources of their own can afford.

The regulatory scheme is not altered by 42 C.F.R. § 447.15. According to section 447.15, "[a] State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency . . . ." The District Court construed this to mean that states rather than providers should be the guarantors of payment. 570 F. Supp. at 288. This interpretation is inconsistent with both the statute and the other regulations. Section 447.15 does not discuss the agency's purported responsibility to the provider for costs of care that are the patient's responsibility. It simply prevents providers from seeking contributions from patients beyond the limits set by Medicaid.

Nor does *Seneca Nursing Home, supra*, cited by the District Court, aid the appellee. In that case, the Tenth Circuit held that a Kansas statute required the state agency to reimburse medical providers for uncollected patient contribu-

tions. 604 F.2d at 1314-15. As we have stated, 42 U.S.C. § 1396a(a)(13)(E) required payment by the state only of the cost of services covered by Medicaid. The statute was silent on the consequences of a state's decision voluntarily to reimburse providers for costs not covered by Medicaid, such as patients' NAMI. However, nothing in *Seneca Nursing Home* permits a state that makes such voluntary reimbursement to receive federal reimbursement for such payments. In any event, there is no New York statute analogous to the Kansas statute in *Seneca Nursing Home*.

CONCLUSION

Both the statute and the regulations make clear that the financial responsibility for patient NAMI is not borne by the Medicaid program. The burden of uncollectible NAMI does not fall on the city, state, or federal government but rather on the institutional provider. The judgment of the District Court is reversed, the injunction is vacated, and the cause is remanded with directions to enter judgment for the defendants.

APPENDIX B

Florence Nightingale Nursing Home v. *Cesar Perales, individually and as Commissioner of the New York State Department of Social Services, and George Gross, individually and as Administrator/Commissioner of the New York City Human Resources Administration*

— F. Supp. — (S.D.N.Y. 1985)

NIGHTINGALE

v.

PERALES,

80 Civ. 5899 (RO)

ENDORSED MEMORANDUM

The motion for summary judgment is granted as to items (i)(a) and (b) for reasons already fully articulated in my prior opinion at 570 F.Supp. 285 which reasoning I have completely reviewed.

It seems to me that where the state proposes to pay to a provider virtually all of a recipient's costs, the provider is not in the same unfettered position to reject any recipient for credit reasons as it would have been were the recipient to be paying all of the costs personally. In the latter situation, a nursing home can make up its own mind as to whether or not it chooses to accept the credit risk involved. It seems to me that the right to reject a recipient-patient becomes illusory where the state has committed itself to pay virtually all the cost. Thus as between the provider and the state, I deem it the state's responsibility to stand behind the credit risk. See Fn. 2 of my prior opinion in accord, 570 F.Supp. at 289, setting forth the legislative history which envisions that the provider will be paid in full when it undertakes to serve a needy recipient.

I am aware that there are federal regulations (see 42 C.F.R. §§ 435.725(a), 435.832, 435.852(a), 435.1002 (b), and 435.733) which are inconsistent with the view I have taken. I remain unpersuaded that Congress intended the provider to have to risk potentially crippling credit losses attendant upon providing services to needy recipients that the state tenders as almost completely funded.

Summary judgment is denied as to item (i)(c) since there are issues as to the amount and nature of the back bills. The parties are to appear before me on September 13, 1985 at 12:45 p.m., Courtroom 128 to set a day for trial of said open issues. Submit order on notice.

Dated: New York, New York
July 12, 1985

/s/ RICHARD OWEN

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United States District Judge

APPENDIX C

Florence Nightingale Nursing Home v. *Cesar Perales, individually and as Commissioner of the New York State Department of Social Services, and George Gross, individually and as Administrator/Commissioner of the New York City Human Resources Administration*

570 F. Supp. 285 (S.D.N.Y. 1983)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

July 27, 1983

No. 80 Civ. 5899 (RO)

FLORENCE NIGHTINGALE NURSING HOME,

Plaintiff,

v.

BARBARA B. BLUM, individually and as Commissioner of the New York State Department of Social Services, *et al.*,

Defendants.

OPINION AND ORDER

OWEN, District Judge.

Plaintiff Florence Nightingale Nursing Home ("Nightingale") is a duly licensed, skilled nursing facility and provider of medical services, and a participant in the federal Medicaid program, 42 U.S.C. § 1396, *et seq.* Defendant Barbara B. Blum (the "State") is the Commissioner of the New York State Department of Social Services. Defendant Stanley Brezenoff (the "City") is the Administrator/Commissioner of the New York City Human Resources Administration. From January 1, 1976 until December 1, 1978, the New York City Human Resources Administration acted as the administering agent of the Medicaid program within its jurisdiction pursuant to the State's delegation of author-

ity.[1] For the remainder of the period covered by plaintiff's complaint, the State directly administered the program. The legal liability of the State for actions taken by the City during its period of administration is at issue in this action.

Plaintiff's claims arise from its participation as a provider of medical services in the Medicaid program. Under that program the federal government allocates funds to participating states in order that those states may channel the allocated monies to provide health care for qualifying individuals. Among the specific uses to which Medicaid money is applied is the reimbursement of certain health-related facilities ("providers") for costs incurred by them in servicing the medical needs of individuals qualified to receive assistance under the program ("recipients").

New York State participates in the Medicaid program. Nightingale participates in the program as a provider and is party to a contractual agreement with the State, known as a Provider Agreement, which together with the federal statute and regulations sets the terms of the relationship between the State and Nightingale. Nigthingale, in this action, has sought relief against the State on both contractual and statutory grounds.

At the heart of plaintiff's complaint are two contentions which raise questions under the reimbursement portions of the statute and Provider Agreement. First, plaintiff com-

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[1] Plaintiff has named both the City and the State as defendants on its claims. Initially, the City filed cross-claims against the State alleging that the State should be ultimately liable on any damages which it—the City—was found to owe plaintiff. On April 28, 1983, those cross-claims were settled. Plaintiff is still asserting its claims against both the City and the State. Nevertheless, because the State's contentions on this motion are largely jurisdictional in nature, the apportionment of liability as between the State and the City is not before me at this time. I therefore will discuss the present motion by referring only to the State except where it is necessary to differentiate between the two.

plains that the State, in contravention of its statutory and contractual duties, has left it to bear the cost of the residual liabilities that arise when a recipient of Medicaid benefits, who is also personally liable for part of the cost of medical services, fails to make good on this debt. As a corollary to this claim, plaintiff asserts that the State has left it with the burden and cost of collecting these obligations. Second, plaintiff contends that both the City and State defendants have wrongfully refused to pay on duly submitted bills for services it provided to qualifying Medicaid recipients.

Now before me is the motion of the State defendant to dismiss this action, in whole or in part. It contends (1) that subject matter jurisdiction is lacking; (2) that the Eleventh Amendment prohibits federal district courts from taking jurisdiction of so much of plaintiff's action as seeks the retroactive payment of state funds, *e.g.*, *Edelman* v. *Jordan*, 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974); and (3) that even if federal subject matter jurisdiction attaches, plaintiff has failed to state a claim.

Plaintiff's complaint raises complex questions of federal statutory interpretation. Plaintiff, in sum, is seeking a declaration from the Court to the effect that the State defendant is not administering its Medicaid program in conformity with the guidelines set forth by the Medicaid statute, *supra*. Having raised issues pursuant to that statute, the Supremacy Clause of the United States Constitution, and § 1983, plaintiff's federal claims have jurisdictional basis under 28 U.S.C. § 1343. *Cf. Seneca Nursing Home* v. *Kansas State Board of Social Welfare*, 490 F.2d 1324 (10th Cir. 1974) at 1328 (wherein the Court of Appeals considered whether jurisdiction lay to hear an analogous question of law and concluded that the "claims of conflict between the Kansas [State Plan] and the federal statutes . . . are not so wholly insubstantial that federal jurisdiction does not exist.")

Jurisdiction of plaintiff's complaint is barred to the extent that the Eleventh Amendment prohibits the prosecution of suits seeking the retroactive payment of state funds in the federal courts. *Edelman* v. *Jordan, supra.*

Upon this record, however, it is unclear whether the State will be ultimately liable for total, partial, or any reimbursement or whether such reimbursement is, in fact, chargeable to federal or city funds. Therefore, the State's motion to dismiss on Eleventh Amendment grounds is denied at this time without prejudice to its renewal at a later time upon a more complete record.

Turning to the substantive claims, I find that Nightingale has adequately pleaded claims for relief. The State first contests the so-called N.A.M.I. reimbursement procedure. Certain recipients of Medicaid, although eligible for some assistance under the program, also have financial assets of their own. These assets have been termed Net Available Monthly Income ("N.A.M.I."). Recipients with N.A.M.I. are required by Medicaid to bear part of the cost of the medical services they receive. At issue here is whether the State should be responsible for collecting N.A.M.I. and bearing the loss for uncollected N.A.M.I. or whether the providers should bear those burdens.

New York has not always dealt with the N.A.M.I. question in the way that it does today. Between July 1, 1976 and July 2, 1978, the State and its providers, including Nightingale, treated N.A.M.I. collection in the following manner. The State imposed the initial collection burden on providers but, where a provider was unable to collect the funds due, the State permitted the provider to resubmit its bill and the State then reimbursed the provider for uncollected N.A.M.I. Thus, for that two-year period, the State acted as a guarantor.

On or about July 2, 1979, however, the State changed its procedures. It informed providers, including Night-

ingale, that they would no longer be reimbursed for uncollected N.A.M.I. Further, the State announced that this new policy would be retroactive to June, 1978 and that it would also apply to any unpaid bills for services rendered prior to that date. Since June, 1978 the State has continued to deduct an amount equal to recipients' N.A.M.I. from reimbursements paid to Nightingale. In those instances where Nightingale has been unable to collect its N.A.M.I., the State has refused and continues to refuse to reimburse it.

The State's motion on the N.A.M.I. issue, therefore, poses the following dispute. On the one hand, Nightingale claims that the Medicaid statute requires that providers be reimbursed for their services on a cost-related basis, that is, that the State pay providers for the reasonable expenses incurred to provide care. On the other hand, the State contends that the Medicaid statute either calls for reimbursement on the basis of recipients' means or is silent on this aspect of the program and leaves to the State the determination of who is to bear the burden of collecting N.A.M.I. Because I find that the statute allocates these burdens to participating states, the motion to dismiss plaintiff's N.A.M.I. claims for failure to state a claim is denied.

The Medicaid statute directs that:

> A state plan for medical assistance must . . . (13) provide— . . . (E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on *a reasonable cost basis,* as determined in accordance with methods and standards which shall be developed by the State on the basis of the cost-finding methods approved and verified by the Secretary . . . .

42 U.S.C. § 1396a(a)(13)(E) (emphasis added). In spite of this language, the State argues that § 1396a(a)(13)(E), without more, leaves open the reimbursement

question. While I would not dispute that the language of § 1396a(a)(13)(E) is summary in its allocation of the reimbursement burden to the State, it nevertheless clearly calls for a cost-based reimbursement program. Moreover, other sections of the Medicaid statute support this determination. For example, § 1396k provides participating states with certain powers to assist in their collection process.

In addition, numerous provisions in the regulations promulgated by the Department of Health and Human Services indicate that it is the Department's view that states, and not providers, are the guarantors of payment. Thus, 42 C.F.R. § 447.15 states that:

> A state plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency.

Cf. 42 C.F.R. §§ 447.201(b), 447.301, 447.302(b), 447.331, and 447.273.

Moreover, while the precise question I decide today has not been ruled on by any other court, the Court of Appeals for the Tenth Circuit has reached a similar conclusion in an analogous case. *Seneca Nursing Home* v. *Secretary of Social and Rehabilitation Services of Kansas,* 604 F.2d 1309 (10th Cir. 1979). There, a dispute arose between a group of nursing homes and the State of Kansas over which of the two was ultimately liable to collect reimbursement payments chargeable to the private resources of welfare recipients. The Court resolved the question in favor of the nursing homes. It explained that:

> [the issue] is whether [the state agency] can refuse payment with respect to nursing home charges alleg-

> edly attributable to uncollected private liabilities payable from other patient resources. In essence [the state agency] argues that when it has established a formula as to how much the patient should be able to provide from his or her private resources, it agrees to pay only the difference between that sum and the total "reasonable, usual and customary" charges of the nursing home. It argues that the nursing home must demonstrate it has exhausted all efforts, apparently including legal action, in an attempt to obtain the payments the patients are to provide from their own resources before [the state agency] can be required to pay such charges. It is not clear [the state agency] agrees to pay the charges even if all collection efforts fail; but at least the argument appears to be that the state agency is no more than the guarantor of last resort. We are not persuaded.

Id. at 1314. While the Court of Appeals in the *Seneca* case was directing its opinion to another facet of the Medicaid reimbursement issue, I find that its reasoning is applicable to this question as well.

Finally, my holding today is consonant with federal policy. Congress created Medicaid to provide medical assistance and rehabilitative and other services to individuals who have demonstrated both medical and financial need. See 42 U.S.C. § 1396. Because the government does not directly provide medical services, Congress, in order to meet these needs, had to both allot funds in lieu of private payments for medical services and find and encourage individuals and institutions to provide the needed medical services. It is this second concern which the Medicaid statute addresses in 42 U.S.C. § 1396a(a)(13)(E) by ensur-

ing that providers will be reimbursed on the basis of their reasonable costs.[2]

Plaintiff's second set of claims arises out of the defendants' failure to timely pay bills which it submitted for medical services it performed. Nightingale alleges that it timely submitted a number of bills to the City and State agencies administering Medicaid which were either lost or delayed in processing. Nightingale claims, moreover, that the State has now refused to pay on those bills. As a partial defense to this claim, the State contends that it had delegated the repayment obligation from January 1, 1976 until on or about December 1, 1978 to the City.

Whatever the dealings were between State and City, it is clear that plaintiff has stated a federal claim. Section 1396a (a)(37) states that a state plan for medical assistance must

> provide for claims payment procedures which (a) ensure that 90 per centum of claims for payment . . . are paid within thirty days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt . . . .

Should the facts in this case demonstrate to me that the defendants are not in compliance with this section, relief will be appropriate. Moreover, I am not persuaded, as the State would have me be, that the State could repudiate its timely

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[2] The legislative history addresses the need to encourage medical institutions to participate in the plan, as well. Speaking generally of the provisions of the plan that govern state payments to providers, the Senate Report states, "these provisions give reassurance that the hospital bill incurred by a needy individual *shall be paid in full* under the provisions of the State plan . . . and that States may not expect to require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill." S.R. No. 404, 89th Cong. 1st Sess. 87 (1965), U.S. Code Cong. & Admin. News, p. 1943.

repayment obligations by merely shifting part of its administrative burden to the City. The statute requires participating states to lodge all administrative responsibility for Medicare in a "single State agency." *See* 42 U.S.C. § 1396a (a)(5). Whether or not a state chooses to delegate part of this responsibility to another governmental unit, the statute makes clear that responsibility ultimately remains with the single State agency.

This very question was presented to the Massachusetts federal district court, which held:

> it is clear that Title XIX mandates full and prompt payment by states to Medicaid providers for inpatient care. Thus, so long as [a state] participates in the Title XIX Medicaid program, federal law requires that [that state] promptly pay the full actual reasonable costs of inpatient care . . . . Any failure to do so, regardless of the reason, is a violation of the Social Security Act.

Massachusetts General Hospital v. *Sargent*, 397 F.Supp. 1056, 1062 (D.Mass. 1975). Finally, plaintiff has adequately pleaded its state contract law claim on its two-year-old bills arising out of the Provider Agreement over which I have pendent jurisdiction. I therefore find that plaintiff states a claim upon which relief can be granted.

Submit order on notice.

APPENDIX D

Judgment of the Court of Appeals

Florence Nightingale Nursing Home v. *Cesar Perales, individually and as Commissioner of the New York State Department of Social Services, and George Gross, individually and as Administrator/Commissioner of the New York City Human Resources Administration*

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

Docket Nos. 85-7755, 85-7759

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the twenty-fourth day of January, one thousand nine hundred and eighty-six.

Present:

HON. IRVING R. KAUFMAN,
HON. WILLIAM H. TIMBERS,
HON. JON O. NEWMAN,

Circuit Judges,

FLORENCE NIGHTINGALE NURSING HOME,

Plaintiff-Appellee,

--v—

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as administrator/Commissioner of the New York City Human Resources Administration,

Defendants-Appellants.

Appeal from the United States District Court for the Southern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Southern District of New York, and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged and decreed that the Judgment of said District Court be and it hereby is reversed, the injunction is vacated, and the action be and it hereby is remanded to the said district court for further proceedings in accordance with the opinion of this court.

ELAINE B. GOLDSMITH,
Clerk

By: /s/ EDWARD J. GUARDARO
Edward J. Guardaro
Deputy Clerk

APPENDIX E

Federal Medicaid Act

42 U.S.C. § 1396a(a)(13)(A)

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * *

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing

of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports; . . .

APPENDIX F

S. Rep. No. 1230, 92d Cong., 2d Sess. 287-288 (1972)

Requirements for States Participating in Medicaid To Pay Skilled Nursing and Intermediate Care Facilities on a Reasonable Cost-Related Basis

(Sec. 249 of the bill)

Under the medicare program extended care facilities are reimbursed for the reasonable costs they incur in providing covered services plus, in the case of proprietary institutions, an allowance related to net capital equity. Under medicaid States have been free to develop their own bases for reimbursement to skilled nursing facilities and intermediate care facilities. States generally establish (in advance) per diem or similar basis rates payable for patients receiving skilled nursing facility and ICF care. Concern has been expressed that some skilled nursing facilities and ICF's are being overpaid by medicaid, while others are being paid too little to support the quality of care that medicaid patients are expected to need and receive.

On the other hand the reasonable cost reimbursement approach of the medicare program has in many cases created difficulties for extended care facilities. The detailed and expensive cost-finding requirements can prove cumbersome.

The committee bill would require States to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis by July 1, 1974. This approach is preferable to the arbitrary rate-setting currently in effect in some States which provide no incentive to facilities to upgrade the level of care provided. The States would use acceptable cost-finding techniques (not necessarily those utilized for medicare purposes) to determine reasonable reimbursement and apply to the results appropriate methodologies for determining payment. The methods would have to be approved and validated by the Secretary. The com-

mittee does not intend that this provision should require use of the specific medicare reasonable cost reimbursement formula by States for purposes of reimbursing skilled nursing homes and intermediate care facilities under medicaid, although States are free to choose this option. Rather, the States could develop other reasonable cost-related methods of rate-setting. Whatever methodology is authorized should include adequate procedures for auditing, as necessary, the financial records of an institution. States would not be required to reimburse for luxury services, questionable allowances for depreciation and similar items which they might reasonably choose not to recognize as "reasonable." States would be free to provide for retroactive adjustments of rates or costs to the extent necessary to prevent "windfalls" or unjustifiably low payment. The Secretary would be expected to validate, on site, a State's methodology through ample audits. Reasonable cost-related rates could be determined on a geographic basis, a class basis, or on an institution-by-institution basis.

The committee amendment provides that cost reimbursement methods which the Secretary would find acceptable for a State medicaid program would also be adapted, with appropriate adjustments, in the State for purposes of medicare reimbursement. The Secretary would be permitted to adjust a rate upward where appropriate, to reimburse for specific factors related to medicare requirements (such as keeping a reasonable number of beds available, type of occupancy covered, any additional administrative costs) which are not considered by the State or included in the computation of its medicaid rates. Such adjustments would be distilled into a percentage factor (not in excess of ten percent) so as to simplify reimbursement. These percentage adjustments may be made on a geographic basis of classes of facilities and not necessarily on an institution-

by-institution basis. A similar provision was included in H.R. 17550.

Where a skilled nursing facility is a distinct part of, or directly operated by a hospital, reimbursement would be made for care in such facilities in the same manner as is applicable to the hospital's costs. Where a skilled nursing facility functions in a close formal medical satellite relationship with a hospital (which would be defined in regulations of the Secretary) reimbursement would be made on the basis of costs not to exceed 150 percent of the adjusted medicaid rate of payment (if the Secretary applies such rates to medicare facilities in that State) for care in that facility (or comparable facility).

This approach avoids substantial auditing and cost-finding expense, and provides a means of making equitable adjustments where appropriate.